8 Hospital Center Blvd., Suite 110
Hilton Head Island, SC 29926
Ph: 843-681-4966 Fax: 843-681-6387

Dear Patient:

We are happy to welcome you to our physician's practice and want you to know that we appreciate the opportunity to take care of you and your family. Our office is focused on delivering world class patient care.

Enclosed, you will find new patient registration forms as well as new patient medical history forms. Please complete the forms and return them to the office (i.e. mail, fax, drop them by) at your earliest convenience.

It is our policy to ask all new patients to be in the office 15 minutes prior to their appointment to scan insurance card(s) and picture ID.

Thank you for choosing our office. We are looking forward to meeting you.

Sincerely,
Doctors and Staff

COMMUNICATION CONSENT

In compliance with federal law, it is the policy of Medical Associates of the Lowcountry Neurology to **NOT** release confidential, personal, and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cellular telephone, pager and/or fax. We will not leave a message on an answering machine where the recorded message does not identify the name or number called. Information will not be left with an unauthorized person who may answer your telephone.

I authorize Medical Associates of the Lowcountry Neurology to leave medical information pertaining to my care by the following methods and will assume responsibility to notify Medical Associates of the Lowcountry Neurology whenever this information changes.

Please list authorized numbers:

Home Telephone _____

Answering Machine _____

Work Telephone _____

Voice Mail _____

Cellular Telephone _____

E-Mail Address _____

I authorize Medical Associates of the Lowcountry to leave medical information pertaining to my care to the following person/persons and will assume responsibility to notify Medical Associates of the Lowcountry whenever this information changes.

Please list authorized names and numbers:

Spouse/Significant Other _____

Parent _____

Brother/Sister _____

Son/Daughter _____

Friend _____

PRIVACY PRACTICE ACKNOWLEDGMENT

I have received a copy of Medical Associates of the Lowcountry Neurology Notice of Privacy Practices.

X_____ Date: _____
Patient Signature / Social Security Number

X_____Date: _____
Guardian Signature *(if patient is under 18)*

Patient Legal Name_____Nickname_____

Patient's Social Security # _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Cell # _____

Email address:_____

Sex ( ) M ( ) F Single Married Divorced Widowed (Circle one)

Race _____ Language _____ Ethnicity _____

Patient Employer _____Employer Phone #_____

Spouse/Guardian Name _____ DOB _____

In Case of Emergency Contact _____

Relationship _____ Phone # _____

Primary Insurance Coverage:

Insurance Company _____

Policy Number _____Group Number_____

Address _____

Name of subscriber _____Date of Birth of subscriber _____

Secondary Insurance Coverage:

Insurance Company _____

Policy Number _____Group Number_____

Address _____

Name of subscriber _____Date of Birth of subscriber _____

Referred by: _____ Primary Care Provider:_____

How did you hear about or Clinic (circle) Friend Newspaper Advertisement

Other _____

Is this office visit related to an automobile accident? Yes/no

Is this claim to be handled through automobile or worker's comp insurance? Yes/no

Insurance Authorization Assignment

I authorize Medical Associates of the Lowcountry Neurology to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Orthopedic Associates of the Lowcountry d/b/a Medical Associates of the Lowcountry Neurology. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

Signature of Patient and/or Guardian _____

Date _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Orthopedic Associates of the Lowcountry d/b/a Medical Associates of the Lowcountry Neurology, for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient and/or Guardian _____

Date _____

Lab Election and Authorization

If lab are ordered by my physicians, my preferred lab is ( ) Hilton Head Hospital lab
( ) Bluffton Medical Campus ( ) LabCorp ( ) Qwest ( ) Other _____

Signature of Patient and/or Guardian _____

Date _____

Pharmacy Election

Pharmacy _____ Location _____

Pharmacy phone number_____

8 Hospital Center Blvd., Suite 110
Hilton Head, S.C. 29926
843-681-4966-office
843-681-6387-fax

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____
(Please Print)

Birth Date: _____ SSN: _____

I hereby authorize: _____

Office Address: _____

Office Telephone: _____ Fax: _____

Please forward copies of the following to:

Medical Associates of the Lowcountry Neurology
8 Hospital Center Blvd., Suite 110
Hilton Head, S.C. 29926
843-681-4966 PH 843-681-6387 FAX

____ All Medical Records _____ Office Notes

_____ Lab Reports _____ Radiology Reports

____ History & Physical _____ Operative Reports

____ Consultation Reports _____Other_____

It is understood that client records are protected under Federal (42 CFR Part 2) and state confidentiality regulations and cannot be released or disclosed without written consent. It is understood that this information is not to be released and that this consent expires one year subsequent to the signing of this release, unless specified for a shorter period of time.

Patient Signature: _____Date: _____

Relationship to Patient (If requestor is not the patient)_____

Name: _____Date of Birth: _____

Marital Status: _____Children: (M)_____(F)_____

Living Will / Healthcare Proxy: ( ) YES ( ) NO Reason for visit today: _____

Current problem is the result of a(n): ( ) Car Accident ( )Work Accident ( )Other Date of injury:_____

Social History

	YES	NO	How many times p/day
Tobacco			
Alcohol			
Exercise			
Caffeine			

Family History

Disease	Relation

Medication allergies: _____ Preferred Pharmacy:_____

Medications

Attach a list if additional space is needed

Name	Dose	Frequency

Are you taking Coumadin? yes/no
Are you taking aspirin or aspirin products? yes/no

Surgeries/Hospitalization

	Year	Complications

Have you ever had any problems with anesthesia? ( )Yes ( )No

Medical History Review of Systems

Are you currently experiencing any of the following conditions?
Answer "**YES**" by checking the appropriate symptom:

Constitution

- O Fever
- O Weight Loss
- O Excessive Fatigue
- O Night Sweats

Eyes

- O Wear Glasses- Date of last exam_____
- O Infections
- O Injuries
- O Glaucoma
- O Cataracts

Ear, Nose, Throat and Mouth

- O Wear hearing aids- Date of last exam_____
- O Hearing loss
- O Ear pain
- O Ear infections
- O Ringing in the Ear ( )Left ( )Right ( )Both
- O Balance disturbance (e.g. vertigo, shining)
- O Nosebleeds
- O Nasal congestion
- O Nasal drainage ( )Amount_____ ( )Color_____
- O Inability to smell
- O Sinus problems
- O Sinus headaches
- O Sore throats
- O Mouth Sores

Cardiovascular

- O Chest Pain/Angina- Date of last EKG:_____
- O High Blood pressure
- O Irregular pulse
- O Heart murmur
- O High cholesterol
- O Swelling in feet/hands
- O Leg pain while walking
- O Persistent Weakness

Respiratory

- O Asthma
- O Chronic cough
- O Emphysema
- O Shortness of breath
- O Bronchitis
- O Pneumonia
- O Lung cancer
- O Bloody sputum
- O Date of last chest x-ray

Gastrointestinal

- O Indigestion or pain with eating
- O Nausea
- O Vomiting
- O Blood in vomit
- O Liver Disease
- O Jaundice
- O Abdominal pain
- O Change in your bowel habits
- O Ulcers or gastritis
- O Colon Cancer

Genitourinary

- O Urinary tract infection
- O Painful urination
- O Blood in your urine
- O Difficulty starting/stopping stream
- O Incontinence
- O Kidney stones
- O Prostate cancer (males)
- O Endometriosis (females)

Musculoskeletal

- O Broken bones- List:_____
- O Arm or leg weakness
- O Back pain
- O Arm or leg pain
- O Joint pain or swelling
- O Arthritis

Integumentary

- O Skin disease
- O Skin cancer
- O Breast pain, tenderness, swelling
- O Nipple discharge
- O Date and result of last mammogram:_____

Endocrine

- O Diabetes
- O Thyroid disease
- O Increased appetite
- O Excessive thirst or urination
- O Hormone problems

Neurological

- O Fainting spells or "blacking out"
- O Seizures
- O Problems with your memory
- O Disorientation
- O Difficulty with your speech
- O Inability to concentrate
- O Double or blurred vision
- O Face weakness
- O Coordination problems in arms and/or legs

Psychiatric

- O Anxiety
- O Depression
- O Other psychiatric disorder/treatment:_____

Hematologic/Lymphatic

- O Anemia
- O Hemophilia
- O Bleeding tendencies
- O Persistent swollen glands or lymph nodes
- O Blood transfusion-If yes, when?_____

Allergic/Immunologic

- O Food allergies
- O Inhalant (nasal) allergies
- O Immunologic disorders

Additional medical information: _____

To the best of my knowledge, the above information is accurate.

Signature: _____ **Date:** _____

Financial Policy

We hope to make your visits in our office as thorough and pleasant as possible. We also want you to have a full understanding of our financial policies and expectations for payment for services. Please carefully review and sign our financial policy, and let us know of any questions you may have.

The primary and final relationship is between the physician(s) (Medical Associates of the Lowcountry Neurology) and you (the patient) and our contract is with you. We will not compromise your medical care to satisfy **ANY** insurance company. Bear in mind, insurance is meant to help defray the cost of medical care and is **NOT** intended to dictate your treatment.

Payment is due and expected in full at the time services are rendered. This includes co-payments and any balances on your account which may be your deductible, co-insurance and non-covered services.

As a courtesy we are happy to file your insurance claims, complete insurance forms, and obtain insurance pre-certification. You will be responsible for any and all balances not covered by your insurance. If your insurance has not paid their portion within 60 days of being properly billed, the entire balance will be your responsibility. If you are unsure of any specific requirements of your insurance, **PLEASE ASK THEM**. We are unable to be completely familiar with every type of insurance and plan. As the insured client, you are in the best position to follow up and exert pressure on your insurance carrier to ensure payment is being processed.

You will receive a monthly statement requesting payment of any unpaid balance. If your account becomes past due, please contact our office to discuss payment arrangements and avoid further collection efforts. We are committed to being sensitive to patient financial difficulties, but we are unable to assist if you do not contact us to discuss your account. If your account goes 90 days unpaid, the account will be turned over to a collection agency.

There is a fee (currently $35) for any checks returned by the bank. Appointments not cancelled with 24 hour notice may result in charges for time reserved.

We are here to serve your health needs and will work hard on your behalf, to contain fees and other charges while providing you with quality health care.

I have read and understand the above policies. I understand that I may receive a copy of this form upon request.

_____

Print Patient Name

X_____

Signature of Patient or Responsible Party

_____ _____

Witness Date

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____ _____
Name of Patient Signature of Patient

_____ / _____ / _____
Date Signed

_____ _____
Name Patient's Personal Representative Signature of Patient's Personal Representative

_____ / _____ / _____
Date Signed

FOR INTERNAL USE ONLY

_____ _____
Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

- ☐ Patient was unable to sign.
- ☐ Patient refused to sign.
- ☐ Other _____
  _____

Version 3 August 2013 (Notice Dated: As noted on NPP) 09/ 23/ 2013 (Date: As noted on NPP)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who Presents this Notice

This Notice describes the privacy practices of ***Medical Associates of the Lowcountry Neurology*** and members of its workforce, as well as the physician members of the medical staff and allied health professionals who practice at the Practice. The Practice and the individual health care providers together are sometimes called "the Practice and Health Professionals" in this Notice. While the Practice and Health Professionals engage in many joint activities and provide services in a clinically integrated care setting, the Practice and Health Professionals each are separate legal entities. This Notice applies to services furnished to you at the Practice as a Practice patient or any other services provided to you in a Practice-affiliated program involving the use or disclosure of your health information.

Privacy Obligations

The Practice and Health Professionals each are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. The Practice and Health Professionals use computerized systems that may subject your Protected Health Information to electronic disclosure for purposes of treatment, payment and/or health care operations as described below. When the Practice and Health Professionals use or disclose your Protected Health Information, the Practice and Health Professionals are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

Permissible Uses and Disclosures Without Your Written Authorization

In certain situations your written authorization must be obtained in order to use and/or disclose your PHI. However, the Practice and Health Professionals do not need any type of authorization from you for the following uses and disclosures:

Uses and Disclosures for Treatment, Payment and Health Care Operations. Your PHI, may be used and disclosed to treat you, obtain payment for services provided to you and conduct "health care operations" as detailed below:

- Treatment. Your PHI may be used and disclosed to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, you may be contacted to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your PHI may also be disclosed to other providers involved in your treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because if you do, this may impact your recovery.

- Payment. Your PHI may be used and disclosed to obtain payment for services provided to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("Your Payor") to verify that Your Payor will pay for health care. The physician who reads your x-ray may need to bill you or your Payor for reading of your x-ray therefore your billing information may be shared with the physician who read your x-ray.

- Health Care Operations. Your PHI may be used and disclosed for health care operations, which include

internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you. For example, PHI may be used to evaluate the quality and competence of physicians, nurses and other health care workers. PHI may be disclosed to the Practice Compliance & Privacy Office in order to resolve any complaints you may have and ensure that you have a comfortable visit. Your PHI may be provided to various governmental or accreditation entities such as the Joint Commission on Accreditation of Healthcare Organizations to maintain our license and accreditation. In addition, PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of the Practice and Health Professionals.

Use or Disclosure for Directory of Individuals in the Practice. The Practice may include your name, location in the Practice, general health condition and religious affiliation in a patient directory without obtaining your authorization *unless* you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or minister, even if they do not ask for you by name. If you do not wish to be included in the facility directory, you will be given an opportunity to object at the time of admission.

Disclosure to Relatives, Close Friends and Other Caregivers. Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you who is involved in your health care or helps pay for your care. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the Practice and/or Health Professionals may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, the Practice and/or Health Professionals would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Health Oversight Activities. Your PHI may be disclosed to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. For example, your PHI may be disclosed to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the facility.

Correctional Institution. You PHI may be disclosed to a correctional institution if you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain requests to us.

Business Associates. Your PHI may be disclosed to business associates or third parties that the Practice and Health Professionals have contracted with to perform agreed upon services.

Decedents. Your PHI may be disclosed to a coroner or medical examiner as authorized by law.

Organ and Tissue Procurement. Your PHI may be disclosed to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Research. Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board approves a waiver of authorization for disclosure.

Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

Specialized Government Functions. Your PHI may be disclosed to units of the government with special functions, such as the U.S. military, the U.S. Department of State under certain circumstances such as the Secret Service or NSA to protect, for example, the country or the President.

Workers' Compensation. Your PHI may be disclosed as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of a medical device.

Appointment Reminders. Your PHI may be used to tell or remind you about appointments.

Fundraising. Your PHI may be used to contact you as a part of fundraising efforts, unless you elect not to receive this type of information.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Use or Disclosure with Your Authorization. For any purpose other than the ones described above, your PHI may be used or disclosed only when you provide your written authorization on an authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before your PHI can be sent to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

Marketing. Your written authorization ("Your Marketing Authorization") also must be obtained prior to using your PHI to send you any marketing materials. (However, marketing materials can be provided to you in a face-to-face encounter without obtaining Your Marketing Authorization. The Practice and/or Health Professionals are also permitted to give you a promotional gift of nominal value, if they so choose, without obtaining Your Marketing Authorization). The Practice and/or Health Professionals may communicate with you in a face-to-face encounter about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without Your Marketing Authorization.

In addition, the Practice and/or Health Professionals may send you treatment communications, unless you elect not to receive this type of communication, for which the Practice and/or Health Professionals may receive financial remuneration.

Sale of PHI. The Practice and Health Professionals will not disclose your PHI without your authorization in exchange for direct or indirect payment except in limited circumstances permitted by law. These circumstances include public health activities; research; treatment of the individual; sale, transfer, merger or consolidation of the Practice; services provided by a business associate, pursuant to a business associate agreement; providing an individual with a copy of their PHI; and other purposes deemed necessary and appropriate by the U.S. Department of Health and Human Services (HHS).

Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental illness, mental retardation and developmental disabilities; (3) is about alcohol or drug abuse or addiction; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about communicable disease(s), including venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult; or (9) is about sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, the Practice and Health Professionals are not required to agree to these requested restrictions.

You may also request to restrict disclosures of your PHI to your health plan for payment and healthcare operations purposes (and not for treatment) if the disclosure pertains to a healthcare item or service for which you paid out-of-pocket in full. The Practice and Health Professionals must agree to abide by the restriction to your health plan EXCEPT when the disclosure is required by law.

If you wish to request additional restrictions, please obtain a request form from the Practice and submit the completed form to the Practice. A written response will be sent to you.

Right to Receive Confidential Communications. You may request, and the Practice and Health Professionals will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the Practice and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Practice identified below.

Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by the Practice and Health Professionals in order to inspect and request copies of the records. Under limited circumstances, you may be denied access to a portion of your records. If you desire access to your records, please obtain a record request form from the Practice and submit the completed form to the Practice. If you request copies of paper records, you will be charged in accordance with federal and state law. To the extent the request for records includes portions of records which are not in paper form (e.g., x-ray films), you will be charge the reasonable cost of the copies. You also will be charged for the postage costs, if you request that the copies be mailed to you. However, you will not be charged for copies that are requested in order to make or complete an application for a federal or state disability benefits program.

Right to Amend Your Records. You have the right to request that PHI maintained in your medical record file or billing records be amended. If you desire to amend your records, please obtain an amendment request form from the Practice and submit the completed form to the Practice. Your request will be accommodated unless the Practice and/or Health Professionals believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, you will be charged for the accounting statement.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Practice Compliance & Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Practice Compliance & Privacy Office will provide you with the correct address for the Director. The Practice and Health Professionals will not retaliate against you if you file a complaint with the Practice Privacy Office or the Director.

Effective Date and Duration of This Notice

Effective Date. This Notice is effective on **September 23, 2013.**

Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that the Practice and Health Professionals maintain, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas around the Practice and on our Internet site at ***www.*_____**. You also may obtain any new notice by contacting the Practice Compliance & Privacy Office.

PRACTICE CONTACTS:

Medical Associates of the Lowcountry Neurology
8 Hospital Center Blvd., Suite110
Hilton Head, S.C. 29910
Telephone Number: 843-681-4966

Corporate Compliance & Privacy Office
Tenet Healthcare
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
E-mail: PrivacySecurityOffice@tenethealth.com
Phone: 1-877-893-8363 ext. 2009
Ethics Action Line (EAL): 1-800-8-ETHICS